

50-STATE SURVEY: LOOK BACK LAWS

Health carrier recovery limitations by state



MARTING
LAW

This document provides a state-by-state overview of statutes and regulations that restrict a health carrier's ability to recover or offset payments once they have been issued. Commonly referred to as "lookback" or "overpayment recovery" limits, these provisions establish timeframes within which a carrier governed by state law may demand repayment from a provider or enrollee, subject to exceptions such as fraud, coordination of benefits, or government program requirements.

Many nuances apply to lookback periods. These include plan type (e.g. self-funded, fully insured, Medicare Advantage, Medicaid), and contractual terms. This resource is provided for informational purposes only and should not be construed as legal advice.

State	Time Period	Lookback Law Language	Statute
Alabama	12 Months	<p>“An insurer, health service corporation, and health benefit plan shall not retroactively deny, adjust, or seek recoupment or refund of a paid claim for health care expenses submitted by a health care provider for any reason, other than fraud or coordination of benefits or for duplicate payments on claims received from the same insurer, health service corporation, or health benefit plan for the same service, after the expiration of one year from the date that the initial claim was paid or after the expiration of the same period of time that the health care provider is required to submit claims pursuant to a contract between the health care provider and an insurer, health service corporation, or health benefit plan, whichever date occurs first.”</p>	AL § 27-1-17
Alaska	12 Months	<p>“A health care insurer may not initiate recovery of an overpayment more than 365 days after the date the original payment was made to a health care provider, health care facility, or consumer, or its agents, unless the health care insurer has clear and documented reason to believe that the health care provider, the health care facility, or consumer, or its agents has committed fraud or other intentional misconduct.”</p>	3 AAC § 26.110
Arizona	12 Months	<p>“Except in cases of fraud, a health care insurer or contracted or noncontracted health care provider shall not adjust or request adjustment of the payment or denial of a claim more than one year after the health care insurer has paid or denied that claim.”</p>	A.R.S. § 20-3102
Arkansas	18 Months	<p>“Except in cases of fraud committed by a healthcare provider, a healthcare insurer may exercise recoupment from a healthcare provider only during the eighteen-month period after the date that the healthcare insurer paid the claim submitted by the healthcare provider.”</p>	A.C.A. § 23-63-1803
California	12 Months	<p>“Reimbursement requests for the overpayment of a claim shall not be made, including requests made pursuant to <u>Section 10123.145</u>, unless a written request for reimbursement is sent to the provider within 365 days of the date of payment on the overpaid claim. The written notice shall clearly identify the claim, the name of the patient, and the date of service, and shall include a clear explanation of the basis upon which it is believed the</p>	Cal Ins Code § 10133.66

		amount paid on the claim was in excess of the amount due, including interest and penalties on the claim. The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider.”	
Colorado	12 Months	“Except as otherwise provided in this subsection (4.5), if there is no contract between a provider and a carrier, adjustments to claims paid to providers shall be made within twelve months after the date of the original explanation of benefits. The time period for adjustments shall be the same for the provider and the carrier.”	C.R.S. § 10-16-704
Connecticut	18 Months	<p>“No contracting health organization shall cancel, deny or demand the return of full or partial payment for an authorized covered service due to administrative or eligibility error, more than eighteen months after the date of the receipt of a clean claim, except if:</p> <p>(A) Such organization has a documented basis to believe that such claim was submitted fraudulently by such provider;</p> <p>(B) The provider did not bill appropriately for such claim based on the documentation or evidence of what medical service was actually provided;</p> <p>(C) Such organization has paid the provider for such claim more than once;</p> <p>(D) Such organization paid a claim that should have been or was paid by a federal or state program; or</p> <p>(E) The provider received payment for such claim from a different insurer, payor or administrator through coordination of benefits or subrogation, or due to coverage under an automobile insurance or workers’ compensation policy. Such provider shall have one year after the date of the cancellation, denial or return of full or partial payment to resubmit an adjusted secondary payor claim with such organization on a secondary payor basis, regardless of such organization’s timely filing requirements.”</p>	Conn. Gen. Stat. § 38a-479b
D.C	6 months general retroactive adjustments after a claim payment.	<p>“(a) A health insurer may only retroactively deny reimbursement to a health care provider:</p> <p>(1) For services subject to coordination of benefits with another health insurer during the 18-month period after</p>	D.C. Code § 31-3133

	18 months if the retroactive adjustment is due to coordination of benefits with another insurer.	<p>the date that the health insurer paid the health care provider; or</p> <p>(2) Except as provided in paragraph (1) of this subsection, during the 6-month period after the date that the health insurer paid the health care provider.”</p>	
Delaware	12 Months <i>Overpayments</i>	“A health insurer or health plan may not initiate overpayment recovery efforts more than 12 months after the original payment for the claim was made. For purposes of this subsection, overpayment recovery efforts are “initiated” when a health insurer or health plan first identifies an error in the original payment for the claim through an initial audit report or similar communication delivered to the health-care provider.”	18 Del. C. § 2730
Florida	30 Months	“All claims for overpayment must be submitted to a provider within 30 months after the health insurer’s payment of the claim.”	Fla. Stat. § 627.6131
Georgia	18 Months	“Any such audit or retroactive denial of payment must be completed and notice provided to the claimant of any payment or refund due within the sooner of 18 months after the claimant’s initial submission of such a claim or 24 months after the date of service.”	O.C.G.A. § 33-20A-62
Hawaii	18 Months	“An entity shall not initiate recoupment or offset efforts more than eighteen months after the initial claim payment was received by the health care provider or health care entity; provided that this time limit shall not apply to the initiation of recoupment or offset efforts: to claims for self-insured employer groups; for services rendered to individuals associated with a health care entity through a national participating provider network; or for claims for medicaid, medicare, medigap, or other federally financed plan; provided that this section shall not be construed to prevent entities from resolving claims that involve coordination of benefits, subrogation, or preexisting condition investigations, or that involve third-party liability beyond the eighteen month time limit; provided further that in cases of fraud or material misrepresentation, an entity shall not initiate recoupment or offset efforts more than seventy-two months after the initial claim payment was received by the health care provider or health care entity.”	HRS § 431:13-108

Idaho			
Illinois			
Indiana	24 Months	<p>“An insurer may not, more than two (2) years after the date on which an overpayment on a provider claim was made to the provider by the insurer:</p> <p>(1) request that the provider repay the overpayment; or</p> <p>(2) adjust a subsequent claim filed by the provider as a method of obtaining reimbursement of the overpayment from the provider.”</p>	Burns Ind. Code Ann. § 27-8-5.7-10
Iowa	24 Months	<p>“Absent a reasonable basis to suspect fraud, an insurer may not audit a claim more than two years after the submission of the claim to the insurer. Nothing in this rule prohibits an insurer from requesting all records associated with the claim.”</p>	191 IAC § 15.33
Kansas	18 Months	<p>“In the event that an insurer erroneously pays a claim providing benefits to which the insured person or provider is not entitled, the insurer shall not initiate a request for reimbursement or refund of that erroneous payment, or in any other way seek to recoup the erroneous payment, unless such action is initiated within 18 months after the end of the month in which the erroneous payment was made.”</p>	K.S.A. § 40-2442
Kentucky	24 Months	<p>“Except in cases of fraud, an insurer may only retroactively deny reimbursement to a provider during the twenty-four (24) month period after the date that the insurer paid the claim submitted by the provider.”</p>	KRS § 304.17A-708
Louisiana	18 Months	<p>“A health insurance issuer shall not retroactively deny, adjust, or seek recoupment or refund of a paid claim for healthcare expenses submitted by a healthcare provider for healthcare services rendered in good faith and pursuant to the benefit plan for any reason after the expiration of eighteen months from the date the initial claim was paid.”</p>	La. R.S. § 22:1838
Maine			
Maryland	6 Months	<p>“(1) If a carrier retroactively denies reimbursement to a health care provider, the carrier:</p>	Md. Insurance Code Ann. § 15-1008

	18 Months for coordination of benefits	<p>(i) may only retroactively deny reimbursement for services subject to coordination of benefits with another carrier, the Maryland Medical Assistance Program, or the Medicare Program during the 18-month period after the date that the carrier paid the health care provider; and</p> <p>(ii) except as provided in item (i) of this paragraph, may only retroactively deny reimbursement during the 6-month period after the date that the carrier paid the health care provider.”</p>	
Massachusetts	12 Months	“The division or an entity with which the division contracts to provide or manage health insurance benefits, including mental health and substance use disorder services, shall not impose a retroactive claims denial for behavioral health services on a provider unless: (i) less than 12 months have elapsed from the time of submission of the claim by the provider to the division or other entity responsible for payment”	ALM GL ch. 118E, § 38A
Michigan			
Minnesota			
Mississippi			
Missouri	12 Months	“Not request a refund or offset against a claim more than twelve months after a health carrier has paid a claim except in cases of fraud or misrepresentation by the health care provider”	RSMo § 376.384
Montana	12 Months	“Except as provided in subsection (3), (4), or (5), if a health insurance issuer does not limit the time in which a health care provider or other person is required to submit a claim for payment, the health insurance issuer may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than 12 months after the payment of an invalid or overpaid claim.”	MCA § 33-22-150
Nebraska		“No insurer shall withhold any portion of any benefit payable or request any refund, on the basis that the sum withheld or the refund requested is an adjustment or correction of an overpayment made on a prior claim arising under the same policy unless: The insurer has notified the claimant within six (6) months of the date of the error, except that in instances of error prompted by	210 NE Admin Rules and Regs ch 60 § 011

		representations or nondisclosures of claimants, the insurer notifies the claimant within fifteen (15) days after the date that clear, documented evidence of discovery of such error is included in its file”	
Nevada			
New Hampshire	12 Months	<p>“No health carrier shall impose on any health care provider any retroactive denial of a previously paid claim or any part thereof unless:</p> <p>(a) The carrier has provided the reason for the retroactive denial in writing to the health care provider; and</p> <p>(b) The time which has elapsed since the date of payment of the challenged claim does not exceed 12 months.“</p>	RSA § 420-J:8-b
New Jersey	18 Months	<p>“With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, no payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than 18 months after the date the first payment on the claim was made. No payer shall seek more than one reimbursement for overpayment of a particular claim.”</p>	N.J. Stat. § 17B:27-44.2
New Mexico			
New York	24 Months	<p>“Health insurer or health maintenance organization may not rely on existing contractual provisions in agreements with health care providers, regarding “look backs,” in attempts to recoup overpayments made to health care providers that were made more than 24 months before; under CLS Ins § 3224-b, unless recoupment efforts had commenced prior to January 1, 2007 effective date of § 3224-b, health plan may “look back” only 24 months to recover overpayments made to providers even where health plan and health care provider had previously agreed to longer “look back” period.”</p>	NY CLS Ins § 3224-b
North Carolina	24 Months	<p>“Subject to the time lines required under this section, the insurer may recover overpayments made to the health care provider or health care facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this section. Not less than 30 calendar days before an insurer seeks</p>	N.C. Gen. Stat. § 58-3-225

		<p>overpayment recovery or offsets future payments, the insurer shall give written notice to the health care provider or health care facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments shall be made within the two years after the date of the original claim payment unless the insurer has reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents, or the claim involves a health care provider or health care facility receiving payment for the same service from a government payor. The health care provider or health care facility may recover underpayments or nonpayments by the insurer by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the insurer may include applicable interest under this section. The recovery of underpayments or nonpayments shall be made within the two years after the date of the original claim adjudication, unless the claim involves a health provider or health care facility receiving payment for the same service from a government payor.”</p>	
North Dakota			
Ohio	24 Months	<p>“A third-party payer may recover the amount of any part of a payment that the third-party payer determines to be an overpayment if the recovery process is initiated not later than two years after the payment was made to the provider. The third-party payer shall inform the provider of its determination of overpayment by providing notice in accordance with division (C) of this section. The third-party payer shall give the provider an opportunity to appeal the determination. If the provider fails to respond to the notice sooner than thirty days after the notice is made, elects not to appeal the determination, or appeals the determination but the appeal is not upheld, the third-party payer may initiate recovery of the overpayment.”</p>	ORC Ann. § 3901.388
Oklahoma	18 Months	<p>“Requesting a refund of all or a portion of a payment of a claim made to a claimant more than twelve (12) months or a health care provider more than eighteen (18) months after the payment is made. This paragraph shall not apply:</p> <p>a. if the payment was made because of fraud committed by the claimant or health care provider, or</p>	36 Okl. St. § 1250.5

		b. if the claimant or health care provider has otherwise agreed to make a refund to the insurer for overpayment of a claim”	
Oregon			
Pennsylvania			
Rhode Island			
South Carolina	18 Months	<p>“An insurer may not initiate overpayment recovery efforts more than eighteen months after the initial payment was received by the provider; however, this time limit does not apply to the initiation of overpayment recovery efforts:</p> <p>(1) based upon a reasonable belief of fraud or other intentional misconduct;</p> <p>(2) required by a self-insured plan; or</p> <p>(3) required by a state or federal government program.”</p>	S.C. Code Ann. § 38-59-250
South Dakota			
Tennessee	18 Months	<p>“Except in cases of fraud committed by the health care provider, a health insurance entity may only recoup reimbursements to the provider during the eighteen-month period after the date that the health insurance entity paid the claim submitted by the health care provider.”</p>	Tenn. Code Ann. § 56-7-110
Texas	Must send letter within 6 Months	<p>“(a) An insurer may recover an overpayment to a physician or health care provider if:</p> <p>(1) not later than the 180th day after the date the physician or provider receives the payment, the insurer provides written notice of the overpayment to the physician or provider that includes the basis and specific reasons for the request for recovery of funds”</p>	Tex. Ins. Code § 1301.132
Utah		<p>“(14) Nothing in this section may be construed as limiting the ability of an insurer to:</p> <p>(a) recover any amount improperly paid to a provider or an insured:</p> <p>(i) in accordance with Section 31A-31-103 or any other provision of state or federal law;</p>	Utah Code Ann. § 31A-26-301.6

		<p>(ii) within 24 months of the amount improperly paid for a coordination of benefits error;</p> <p>(iii) within 12 months of the amount improperly paid for any other reason not identified in Subsection (14)(a)(i) or (ii); or</p> <p>(iv) within 36 months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children’s Health Insurance Program, or</p>	
Vermont	12 Months	<p>“The retrospective denial of a previously paid claim shall be permitted beyond 12 months from the date of payment for any of the following reasons:</p> <p>(1) the plan has a reasonable belief that fraud or other intentional misconduct has occurred;</p> <p>(2) the claim payment was incorrect because the health care provider was already paid for the health services identified in the claim;</p> <p>(3) the health care services identified in the claim were not delivered by the provider;</p> <p>(4) the claim payment is the subject of adjustment with another health plan; or</p> <p>(5) the claim is the subject of legal action.”</p>	18 V.S.A. § 9418
Virginia	12 Months	<p>“No carrier shall impose any retroactive denial of a previously paid claim or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, the carrier has provided a written explanation of why the claim is being retroactively adjusted, and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed 12 months. Notwithstanding the provisions of clause (iii), a provider and a carrier may agree in writing that recoupment of overpayments by withholding or offsetting against future payments may occur after such 12-month limit for the imposition of the retroactive denial. A carrier</p>	Va. Code Ann. § 38.2-3407.15

		shall notify a provider at least 30 days in advance of any retroactive denial or recovery or refund of a previously paid claim.”	
Washington	24 Months	“Except in the case of fraud, or as provided in subsections (2) and (3) of this section, a carrier may not: (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within twenty-four months after the date that the payment was made or, in the case of mental health and substance use disorder services as defined in section 2 of this act, within six months after the date the payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.”	ARCW § 48.43.600
West Virginia	12 Months	“ A health plan may retroactively deny a claim only for the reasons set forth in §33-45-2(a)(7)(A)(iii) through §33-45-2(a)(7)(A)(vi) of this code for a period of one year from the date the claim was originally paid. There shall be no time limitations for retroactively denying a claim for the reasons set forth in §33-45-2(a)(7)(A)(i) and §33-45-2(a)(7)(A)(ii) of this code.”	W. Va. Code § 33-45-2
Wisconsin			
Wyoming	<i>Overpayment</i> 24 Months	“An action or request for reimbursement of any overpayment of a health insurance claim to a health care provider pursuant to any health insurance contract shall be brought not more than two (2) years after the date the claim was paid. No insurer, assignee of the insurer, or other person, whether acting for himself or another in connection with a health insurance transaction, shall make any claim or seek recovery for reimbursement of any overpayment to a health care provider pursuant to any health insurance contract more than two (2) years after the date the claim was paid, unless the claim was fraudulent.”	Wyo. Stat. § 26-15-137